FINAL REPORT
OF THE
HEALTH FINANCE COMMISSION

Indiana Legislative Services Agency
200 W. Washington St., Suite 301
Indianapolis, Indiana 46204-2789

November 2007

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2007

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Health Finance Commission

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A copy of this report is available on the Internet. Reports, minutes, and notices are organized by committee. This report and other documents for this Commission can be accessed from the General Assembly Homepage at http://www.in.gov/legislative/.

FINAL REPORT

Health Finance Commission

I. STATUTORY AND LEGISLATIVE COUNCIL DIRECTIVES

The Indiana General Assembly enacted legislation (IC 2-5-23) establishing the Health Finance Commission to study health finance in Indiana. The Commission may study any topic (1) directed by the chairperson of the Commission; (2) assigned by the Legislative Council; or (3) concerning issues that include the delivery, payment, and organization of health services and rules that pertain to health care delivery, payment, and services that are under the authority of any board or agency of state government.

The Legislative Council assigned the following additional responsibilities to the Commission: (1) study the survey process for long-term care facilities (as proposed in SR 69) and (2) review reports requested by the Legislative Evaluation Oversight Policy Subcommittee and prepared by the Legislative Services Agency evaluation staff concerning (a) a survey of the status of inmate health in the state prison system and (b) an inventory of State Department of Health programs.

II. INTRODUCTION AND REASONS FOR STUDY

SEA 503-2007 requires the Health Finance Commission to study during the 2007 interim the reimbursement rates to providers under, and the premium costs of, accident and sickness insurance policies and health maintenance organization contracts.

The Commission is also required to study the effectiveness of the Indiana Tobacco Use Prevention and Cessation Program and whether the program should be transferred to the State Department of Health.

SEA 193-2007 requires the Commission to study (1) whether hospitals, including specialty hospitals, should be placed under a moratorium from adding or constructing new facilities; (2) whether specialty hospitals should be restricted from presenting their facilities to the public as a hospital; and (3) whether the definition of the term "hospital" under IC 16-18-2-179 should be amended to include or exclude certain specialty health facilities.

SEA 450-2007 requires the Commission to study during the 2007 interim the adequacy of Indiana's regulation of methadone clinics based on a report prepared by the Division of Mental Health and Addiction to be submitted to the Commission.

The Commission is required by HEA 1678-2007 to study whether the acute care hospital in Gary, Indiana, should be converted from a private corporation to a county hospital, a municipal hospital, or other governmental hospital. In considering whether a conversion should occur, the Commission is to consider (1) whether the conversion would result in better quality care that would be sufficient to meet the needs of the community; (2) whether the hospital's finances would be improved; and (3) the legal requirements to convert the hospital.

The bill also requires the Commission to study the following topics: (1) the manner in which a not-for-profit hospital can be converted into a county or municipal hospital; (2) ways in which the state and other entities can encourage physicians to practice in rural and county hospitals; (3) federal guidelines concerning county hospitals and intergovernmental transfers; (4) review of

the use of sources of funding for Medicaid reimbursement and implications for the uses of the funding sources; (5) a prohibition against smoking in public places in Indiana; and (6) mechanisms for providing programs to provide health care coverage for uninsured individuals in Indiana.

Reports Required

The State Department of Health is required by SEA207-2007 to report to the Health Finance Commission not later than September 1 of 2007 and 2008 concerning the implementation of IC 16-40-5 (concerning the progress of implementing adverse event reporting).

HEA 1468-2007 requires the Indiana Board of Pharmacy to study and make findings on the issue of the application of technology in the dispensing of drugs, including the reliance on bar code technology in long-term care pharmacies. The study must include the review of the use of pharmacy technicians when using bar code technology. The Board is required to report the findings of the study not later than November 1, 2007, to the Health Finance Commission.

The bill also requires the State Department of Health (ISDH) to evaluate the current immunization data registry system in consultation with health care providers, and to determine ways to make the registry easier for health care providers to report to and use. The ISDH is required to orally report to the Commission no later than November 1, 2008, on the Department's recommendations and progress toward making the immunization registry easier to use.

Before November 1, 2007, the State Department of Health and FSSA are required by HEA 1348-2007 to orally report to the Commission the agencies' progress in developing a program for the statewide collection of cord blood from pregnant women upon delivery of a newborn.

HEA 1678-2007 also requires the Office of Medicaid Policy and Planning to report to the Commission during the 2007 interim, updating the Commission on the status of the development and implementation of the Indiana Check-Up Plan.

III. SUMMARY OF WORK PROGRAM

The Commission met five times during the 2007 interim. The fourth Commission meeting was held in Gary; all other meetings were held at the State House in Indianapolis.

The first meeting was held July 30, 2007. The meeting was devoted to hearing various reports and determining the schedule of the Commission for the remainder of the interim session. Dr. Jeff Wells presented an update on the progress of the Medicaid waiver necessary to implement the Healthy Indiana Plan. Jessaca Turner-Stults discussed the potential financial impact of the proposed federal Farm Bill that would impose restrictions on the eligibility modernization project in Indiana. The Division of Mental Health and Addiction testified on the findings of their report required by SEA 450-2007 on the regulation of methadone treatment clinics in Indiana. The Legislative Services Agency described the methodology used to collect information for a survey of the status of Indiana inmate health and a program inventory of the State Department of Health as requested by the Legislative Evaluation Oversight Policy Subcommittee and required by the Legislative Council.

The second meeting was held August 15, 2007. Mr. Terry Whitson of the Department of Health gave an overview of the Department's federal regulatory requirements with regard to the

nursing facility survey process. The Commission heard testimony from providers regarding the inconsistency of survey findings and the disruptive nature of the survey process. The Commission also heard testimony from consumer advocates supporting the survey process, criticism that the process is weighted towards the providers, and recommending the process consider more consumer input. The Commission also heard an update on the implementation of licensing regulations for birthing centers and abortion clinics. Mr. Whitson also gave an overview of the Department's adverse event reporting activities and report deadlines. The Commission heard a presentation from the Tobacco Use Prevention and Cessation Program regarding the effectiveness and outcomes of the agency's activities. The Commission took testimony from various parties supporting a statewide ban on smoking in public places. The Commission heard testimony regarding the costs of operating a physician's office in comparison to the Medicaid reimbursement paid for visits. Secretary Roob, Family and Social Services Administration (FSSA), presented an update on the status of the implementation of the Healthy Indiana Plan - the program outlined in HEA 1678-2007 intended to provide subsidized health insurance to low-income adults. Secretary Roob also updated the Commission on the progress of the federal reauthorization of the Children's Health Insurance Program (CHIP). The Department of Insurance reported on the implementation of the HEA 1678-2007 requirement to expand insurance coverage to dependents up to the age of 24 years. The Commission also heard testimony regarding an insurance industry billing practice referred to as "rental or silent preferred provider organizations (PPOs)". The Department of Child Services updated the Commission on child protective services caseworker hiring as requested at a previous meeting.

The third meeting was held September 10, 2007. The meeting began with an overview of methadone treatment in Indiana. The Commission heard testimony regarding the lack of motivation for clinics to aggressively work to wean patients off methadone or to be accountable for their treatment decisions. The Division of Mental Health and Addiction reviewed current operating statutes and rules and made recommendations for changes to statutes and rules necessary to implement increased regulatory oversight of the methadone clinics. The Commission also heard an overview of the role of school nurses and took testimony on the need to provide private insurance parity with Medicare for prosthetics coverage.

The fourth meeting was held October 2, 2007, at IU Northwest in Gary. The meeting was focused on hospital-related issues with an emphasis on continuing the operation of an acute-care hospital in Gary. The meeting began with testimony regarding the effectiveness or desirability of a hospital construction moratorium. The Commission heard testimony regarding statutory and public designations of hospitals and specialty facilities, mostly relating to the availability of emergency services. The Commission heard testimony relating to the healthcare needs of the population residing in Gary and the need for continuing the operation of a general acute care hospital within the city limits; the need for the development of a regional trauma center; and the need to expand the number of physicians practicing in Gary. Dr. Jeff Wells presented a proposal to create an academic medical center partnered with the Indiana University School of Medicine. Family and Social Services Administration Secretary Mitch Roob, reported that the required federal approval for the Medicaid waiver was received allowing for the implementation of the Healthy Indiana Plan. The Commission also heard testimony on ways to encourage physicians to locate their practices in medically underserved areas of the state.

The fifth meeting was held October 29, 2007. The Commission took testimony on the difficulty of convincing insurance companies to cover stereotactic radiosurgery for certain applications. Mr. Alfred Medjesky, a cancer patient eligible for radiosurgery, shared his experience of trying to get the procedure approved for payment by his insurance carrier. The Commission also heard testimony from Anthem Insurance regarding how the company determines the policy for

coverage of innovative treatment modalities. Judith Monroe, MD, State Health Commissioner, reported on methicillin-resistant staphylococcus aureus (MRSA), the toy recall and associated lead-poisoning issues, and the voluntary reporting of childhood growth measurements to the Department of Health. The Commission also heard testimony on prevention and control measures being taken in healthcare institutions for the containment of multi-drug resistant organisms. The Commission also considered legislative bill drafts and approved the Commission's final report.

Two statutorily assigned topics were heard by the Select Joint Commission on Medicaid Oversight. The two topics were the (1) federal guidelines concerning county hospitals and intergovernmental transfers and (2) review of the use of sources of funding for Medicaid reimbursement and implications for the uses of the funding sources.

IV. SUMMARY OF TESTIMONY

The Commission heard testimony on numerous issues over the course of the interim. To read a more complete report of this testimony and other matters considered by the Commission, the minutes of the Commission's five meetings can be found on the Commission's website (http://www.in.gov/legislative/interim/committee/hfco.html), or copies may be obtained by contacting the Legislative Information Center of the Legislative Services Agency.

Healthy Indiana Plan Updates

The Commission heard three updates on the progress of the Medicaid waiver approval process necessary to leverage state funds with federal funds. The federal Centers for Medicare and Medicaid Services (CMS) approved the waiver late in September. Secretary Roob reported that CMS required the use of an enrollment broker, rather than allowing the insurance providers to enroll eligible individuals. Secretary Roob announced to the Commission that marketing of the Healthy Indiana Plan would begin in mid-November, with enrollment to commence in December, and healthcare coverage effective in January.

Federal Legislation Updates

The Commission heard updates from FSSA on the content and progress of two pieces of federal legislation; the Farm Bill which included a prohibition of the privatization of eligibility caseworkers for the federal Food Stamps program; and the reauthorization of CHIP. FSSA reported that should the federal Farm Bill pass with the prohibition included, the state could incur costs of $100 M to $125 M to cancel the IBM contract. Secretary Roob reported that the bill reauthorizing the CHIP program contained a federal cigarette tax increase that would be disadvantageous to Indiana - making the state a revenue donor state with respect to other states' CHIP programs.

Regulation of Methadone Clinics

Mr. John Viernes, Deputy Director of the Division of Mental Health and Addiction, reviewed the findings of the report on the adequacy of methadone clinic regulation. He also distributed a document comparing Indiana statutes concerning methadone clinics with those of surrounding states. Mr. Viernes reviewed the residency of methadone clinic patients and discussed why so many were from out of state. He also reported that for regulatory purposes, the Indiana regulations generally mirror the federal regulations with a few statutorily required exceptions.

Mr. Viernes gave an overview of the Indiana authorizing statutes and rules for the Commission. He reviewed four recommendations for regulatory improvements for the Commission's consideration. The Division recommended (1) requiring defined staffing ratios of licensed professionals to patients in the clinics; (2) requiring specific licensure of addiction treatment professionals; (3) requiring individualized treatment planning for each patient; and (4) restructuring the current fees to allow for annual fees for both in-state and out-of-state patients, clinic certification fees based on the size of the clinic, and the ability to assess fines for noncompliance. An increase in the fee revenue would provide the funding necessary to increase regulatory oversight of the clinics. The recommendations concerning the fees and the licensure of addiction treatment professionals would require statutory changes.

Mr. Joe Pritchard of Indiana Treatment of Opioid Dependency (INTOD), representing 12 of the 14 methadone clinics in the state, distributed information and gave an overview of the methadone treatment program. Mr. Pritchard discussed the demographics of the patient population, how methadone works, and how long the treatment lasts. He stressed that while methadone is a substitute addiction, it is not intended to be a lifelong addiction. He also discussed the efficacy of the treatment relating re-arrest and employment statistics of methadone patients. Mr. Pritchard discussed the problem of drug diversions and noted that methadone may be prescribed for pain in settings other than methadone clinics and that 95% of methadone diverted to the street comes from sources other than methadone clinics. Samples of the liquid products and the containers used in Indiana clinics were displayed for the Commission. Mr. Pritchard also reported that there is no police data that shows a correlation of decreases or increases in local crime rates when a methadone clinic opens or closes.

Vidya Kora, MD, a practicing internist and the LaPorte County Coroner, reported that of nine recent deaths attributable to methadone, seven had clinic sources of the drug. Dr. Kora discussed the historical purpose of methadone to treat heroin addiction and the current practice of using methadone to treat any opioid addiction. Dr, Kora remarked that he is not opposed to methadone treatment but that aggressive efforts need to be made to get patients off the drug. He suggested that the for-profit ownership status of the clinics does not contribute to their motivation to wean the patients from the alternative addiction of methadone as quickly as might be possible. Dr. Kora suggested that the clinics be operated by the State Department of Health.

In response to a question regarding Dr. Kora's suggestion to shift the operation of the methadone clinics to the State Department of Health, Cathy Boggs, Director of the Division of Mental Health and Addiction, remarked that a shift to the not-for-profit sector would be preferable.

Ms. Debbie Frazier of Columbus related her son's experience as a methadone clinic patient of 2.5 years before his death by overdose. Ms. Frazier recommended that the clinics need better programs and to be held more accountable for their results.

LSA Program Evaluation Reports

Ms. Karen Firestone, Audit Leader, Office of Fiscal Management and Analysis, reviewed the methodology used and the format of the Program Inventory for the Indiana State Department of Health prepared by LSA for the Health Finance Commission. The Program Inventory is available on the General Assembly website at http://www.in.gov/legislative/pdf/ProgramInventoryIDOH.PDF.

Ms. Firestone also reviewed the methodology used to compile the Survey of the Status of

Inmate Health in the State Prison System. The report is available on the General Assembly website at http://www.in.gov/legislative/pdf/InmateHealth.PDF.

Survey Process for Long-Term Care Facilities

Mr. Terry Whitson, Assistant Commissioner for Health Regulatory Services of the ISDH, distributed a document entitled "Strategic Plans of 2007". The document addresses improving the long-term care survey process and ongoing federal CMS quality-of-care initiatives and ISDH quality-of-care initiatives. Mr. Whitson described the purpose of licensing and certification activities as being to promote and ensure patient safety and quality-of-care in long-term care facilities. The regulations used in the surveys are primarily established by CMS, with the state serving as the survey agency for all federal certification programs in acute and long-term care. Mr. Whitson reported that CMS routinely conducts oversight and audit activities to evaluate the state's performance.

Mr. Whitson reported on CMS and ISDH initiatives intended to improve quality of care and provided comparisons of Indiana's performance to that of other states. He also reported on initiatives undertaken to communicate with the provider community about concerns regarding the survey process. He also responded to questions regarding the staffing of the survey teams and the consistency of the survey results between regions of the state.

Ms. Faith Laird, representing the Indiana Health Care Association (IHCA), testified that there has been a large increase in the scope and severity of deficiencies cited in Indiana over a two-year period. Ms. Laird provided comparison statistics and recommended (1) an independent review of the survey process in the state; (2) continuation of ongoing joint educational training for surveyors and providers; and (3) institution of a corrective action process for surveyors found to exhibit deficient practices, and measures to assure that the deficient practices do not recur.

Mr. Jim Leich of the Indiana Association for Homes and Services for the Aging stated that his membership believes that problems associated with the survey process need to be addressed. Mr. Leich cited a disruptive process, unfair and inconsistent survey outcomes, and significant differences between regions in terms of levels of violations.

Mr. Robert Decker, Hoosier Owners and Providers for the Elderly, stated that no one doubts there is a problem with consistency. Mr. Decker made several suggestions similar to those made by Ms. Laird and further suggested that an independent evaluation of the survey process could be funded by monies in the Civil Monetary Penalty (CMP) fund. The revenue for this fund comes from nursing facility fines. At a subsequent meeting, Mr. Whitson reported that CMS would not approve the use of the CMP fund for this purpose.

Ms. Arlene Franklin, State Long-Term Care Ombudsman, commented on the apparent bias of the survey procedure towards providers. She testified that ISDH can only use documentation kept by the facilities; they cannot cite a violation based on statements or documentation provided by consumers or their advocates. Ms. Franklin stated that the 22, mostly part-time, local, long-term care ombudsmen do not support any weakening of the survey system, which already uses facility input and documentation to a greater extent than information supplied by consumers for investigations and citations.

Ms. Robyn Grant, Long-Term Care Policy Director for United Senior Action remarked that from a consumer perspective, the ISDH should be commended rather than criticized. Ms. Grant also

stated that residents and families have their own concerns about the survey process, which include the following:
(1) Far too few deficiencies are actually cited; and when ongoing problems are reported to surveyors, nothing happens.
(2) When deficiencies are actually cited, their seriousness or level of severity is frequently discounted.
(3) Annual surveys do not give a true picture of nursing home conditions because nursing homes have geared up and prepared for the survey in advance and the timing of surveys is much too predictable.
(4) Many consumers have an overwhelming sense that the system is stacked against them due to a fear of retaliation against themselves or a loved one for reporting a problem. In addition, nursing facilities have appeal rights, and consumers have no rights to challenge the findings or lack of findings.

Ms. Grant provided two recommendations:
(1) Continue to gather information about the consumer perspective.
(2) Involve consumers just as much as providers in developing any proposed changes to the survey process.

ISDH Update on Regulations for Birthing Centers and Abortion Clinics

Mr. Whitson updated the Commission on the status of birthing center licensure, which began in February 2006. Two birthing centers have applied for licensure and subsequently were inspected and licensed. Mr. Whitson reported that the ISDH is aware of at least one birthing center that is unlicensed due to religious beliefs. The licensure statute does not allow for exceptions. The Department has not taken any action against unlicensed birthing centers pending a legislative determination of whether there should be an exception for religious-based centers. (The primary intent of the licensing requirement was to allow birthing centers to become Medicaid providers.)

Mr. Whitson also updated the Commission on the status of abortion clinic licensure, which began July 1, 2006. Nine clinics filed applications; all of which have been inspected at least once by ISDH nurse surveyors. All nine clinics have fulfilled the requirements and have been issued a license.

ISDH Report on Implementation of Adverse Event Reporting

Mr. Whitson stated that the “Preliminary Medical Errors Report for 2006" was issued March 6, 2007. The final report is to be issued in late August 2007. He also updated the Commission on the progress being made on proposed consensus standards for infection-rate reporting and final federal regulations on patient safety centers.

Indiana Tobacco Use Prevention and Cessation Program Effectiveness and Potential Transfer to the ISDH

Ms. Karla Sneegas, Executive Director of the Indiana Tobacco Use Prevention and Cessation (ITPC) Program, provided a slide presentation describing outcomes and the effectiveness of Indiana’s Tobacco Prevention and Cessation Program. Ms. Sneegas described the recommended interventions of the CDC guide to community preventive services as preventing tobacco product use initiation, reducing exposure to secondhand smoke, and increasing cessation. Ms. Sneegas described Indiana’s three-fold strategy as smoke-free air policies,

higher cigarette prices, and sustained comprehensive community-based tobacco control programs for the goals of prevention and cessation.

Ms. Sneegas described the metrics used by ITPC and provided various statistics associated with the prevalence of adult and youth smoking, proportion of tobacco-free school districts, proportion of smokers making an attempt to quit, number of calls to the quitline, proportion of adults working indoors who report a smoke-free workplace, number of Hoosiers protected from secondhand smoke through local ordinances, and the percentage of grantees that submit quarterly reports on time. The ITPC later provided additional data detailing specific information requested by the Commission.

Ms. Peggy Vols, local coordinator in Bartholomew County, told the Commission that she had been involved with the ITPC from the beginning as an executive board member. She remarked that she believes the ITPC is accomplishing the goals established by the legislature. Ms. Vols stated that she supports the ITPC remaining a separate state agency.

Judith Monroe, MD, Commissioner of the ISDH, stated that as State Health Commissioner, she is committed to decreasing the use of tobacco in the state and wants to work productively with everyone who supports that goal. With regard to the question of whether the ITPC should work under the authority of the Department of Health, Dr. Monroe remarked that she is currently the chair of the ITPC Board. She added that the two agencies have a good working relationship and she would not want to see the momentum to be interrupted. Dr. Monroe reported that the ten states with the lowest smoking rates have tobacco prevention and cessation under their state health departments. She added that there are potential savings in administrative costs and synergy with other ISDH programs that might be realized if the agencies were combined.

Dr. Monroe stated that if the General Assembly were to move the ITPC under the ISDH, she recommends that the ITPC should be structured similar to the Office of Women's Health, which has an advisory board, is legislatively mandated, and cannot be abolished without legislative action. She added that the trust fund should be maintained and Indiana's commitment to sustainable funding for an evidence-based comprehensive tobacco control should be supported.

Ms. Danielle Patterson, Senior Advocacy Director of the American Heart Association stated that the American Heart Association believes the larger issue is for the legislature to commit to using the tobacco settlement funding for its intended purposes and to fully fund the tobacco cessation program wherever it resides at the CDC-recommended level of $34.5 M. She added that the Heart Association would continue to support the work of the ITPC and the ISDH.

Statewide Prohibition Against Smoking in Public Places

Enrico Garcia, MD, President of the Indiana Association of Public Health Physicians and Local Health Department Organizations, Inc., stated that medical professionals and public health officials are concerned with the detrimental effects of tobacco, whether it be primary or secondary effects, on the health of Hoosiers. Based on research, smoking is the single most preventable cause of death and disease in the country. Dr. Garcia stated that 75% of Indiana residents are nonsmokers and that they should be protected from the pollution caused by the smoking minority. He added that he is in support of a smoke-free Indiana.

Ms. Cathy Calloway of the American Cancer Society provided an overview of the smoke-free trend in the nation. Ms. Calloway described the problems associated with secondhand smoke

and how it can cause or exacerbate a wide range of health problems. She stated that research published in leading scientific journals has consistently and conclusively shown that smoke-free laws have no adverse economic effects on the hospitality industry. She added that the American Cancer Society would oppose legislation that included ventilation or smoking rooms.

Ms. Danielle Patterson, American Heart Association, distributed a written statement describing the positive impacts of smoke-free laws on health outcomes. The statement concluded by encouraging the Commission to recommend a comprehensive smoke-free law.

Ms. Debra Salefski, a radiation therapist from Hamilton County, urged the Commission to support a statewide smoke-free law. Ms. Salefski also distributed a statement from Ms. Patricia Ells of the American Cancer Society which described three critical tools for reducing tobacco usage. The tools are (1) passing a high tobacco tax; (2) enacting a comprehensive smoke-free air law; and (3) adequately funding tobacco prevention and cessation programs to help current smokers quit and keep others from starting.

Mr. Bruce Hetrick related how his wife had died of lung cancer, attributed to exposure to secondhand smoke. He commented that employees have a right to be protected from secondhand smoke in their workplaces. Mr. Hetrick reported that 22 states have passed smoke-free laws that include restaurants and bars. He emphasized that he is in support of a ban on smoking in public places that includes restaurants and bars to safeguard citizens and employees.

State Health Commissioner, Judith Monroe, MD, spoke in support of a statewide ban against smoking in public places.

Dr. Terrell Zollinger, IU School of Medicine, addressed the economic impact of secondhand smoke.

Reimbursement Rates to Providers and the Premium Costs of Accident and Sickness Insurance Policies and HMO Contracts

The Commission heard testimony related to the inadequacy of Indiana Medicaid reimbursement for physicians and chiropractors.

Mechanisms for Providing Health Care Coverage for Uninsured Individuals in Indiana

The Commission heard a description of the Healthy Indiana Plan and an update on the progress of the Medicaid waiver application necessary to implement the program. Secretary Roob also gave a status report on the federal reauthorization of the CHIP program.

Report on the Implementation of Expanding Insurance Coverage to Dependents up to Age 24

Ms. Carol Cutter of the Indiana Department of Insurance stated that the provision requiring the coverage of dependents up to the age of 24 years went into effect on July 1, 2007. This provision applies to commercial individual, group, and HMO health insurance plans at the time the contracts are renewed. The coverage applies to all dependents up to age 24, regardless of their status as students, if an employee asks for the coverage. Ms. Cutter explained that employer self-funded programs are not required to provide this extension of coverage since

they are regulated by the federal ERISA statute. She also noted that there may be tax consequences to the employee that asks for the extended coverage.

Rental and Silent Preferred Provider Organizations

Andrew Satz, MD, thanked the members of the Commission for helping to pass legislation prohibiting "most favored nation" clauses in insurance contracts with providers. He described another reimbursement practice which unfairly perpetuates the lowest reimbursement rate among insurers: rental and silent PPOs.

Dr. Satz explained that when physicians contract to join a health plan network, the physicians usually agree to accept a reduced payment rate in return for the plan steering patients into the physician's practice. However, a "silent PPO" is when a contracting network, after negotiating discounts with providers, then sells access to the list of agreed discounts to other insurers who then, without the provider's authorization or knowledge, apply the discounts to their own payments to the provider. The practice effectively robs the physician providers of the ability to choose with whom they contract for discounted services. Dr. Satz stated that not only should there be proper disclosure of this activity, there needs to be consent from the provider to lease, transfer, or sell the discount, or the provider should possess the right to opt out (or maybe there should be some threshold number of patients under which the provider is allowed to opt out).

Ms. Elizabeth Eichorn of the Indiana State Medical Association stated that doctors should be notified when the practice is occurring, and the doctors need to be allowed to provide their consent.

Mr. Greg Yust, President of the Sagamore Health Network, stated that silent PPOs don't let anyone know they exist. He recommended that PPO networks with whom a doctor contracts should provide membership cards to their members with the PPO's identification on it. In addition, he commented that controlling this practice would be difficult to legislate; providers need to look at the contracts they sign.

Eligibility Modernization / Caseworker Outsourcing

Sen. Becker distributed a letter stating that the time to process a child's eligibility for Hoosier Healthwise had gone from an average of 9 days in 2006 to 47 days in June 2007.

Sen. Miller had asked for a report on the Eligibility Modernization Project, but there was not sufficient time to hear the presentation at the final meeting of the Commission.

In response to questions from members, Ms Anne Houseworth of the Department of Child Services updated the Commission on the progress of child protective services caseworker hiring. Ms. Houseworth stated that as of January 1, 2005, there were approximately 600 caseworkers; and as of June 30, 2007, that number had increased to 1,155. Ms. Houseworth added that there are a total of 800 new caseworkers authorized; 400 new caseworkers, net, in each of the last biennium and the current biennium.

Private Insurance Parity with Medicare Benefits for Prosthetics

Ms. Marifran Mattson of the Indiana Amputee Insurance Protection Coalition asked the Commission to consider mandated insurance coverage parity with Medicare benefits for prosthetic coverage. She stated that insurance companies are imposing dollar caps and

restrictions for prosthetics claims. She said that while many people would regard prosthetics as basic medical care for the individuals who need them, most people are not aware of the impact of coverage restrictions and the consequences associated with not getting the appropriate prosthetics. Ms. Mattson stated that a state insurance mandate for parity with the Medicare program would cost approximately $0.12 to $0.35 per member per month, not taking into account any savings resulting from problems otherwise arising due to delays and denials of necessary prosthetic devices. She also commented that insurance parity would decrease cost-shifting to the Veterans Administration, Vocational Rehabilitation, Medicaid, and other government assistance programs.

Kent Turnbow of the Indiana Amputee Insurance Protection Coalition commented that the technology involved in a prosthesis can influence the quality of life for the patient. He compared the $6,000 cost of a prosthetic that uses 30-year-old technology to that of $13,000 for the cost of a prosthetic that uses current technology. He stated that if an insurance policy is capped at $4,000 per year and the patient works, often they will turn to vocational rehabilitation services offered by the state to obtain the prosthetic devise needed. In response to questions, Mr. Turnbow stated that the average life of a prosthesis is about 3 years. However, some prosthetics can be repaired to extend the life of the device at about half the cost of a replacement.

Ms. Amy Mills, age 15, testified that she outgrows her prosthesis every 9 to 10 months. Her family experienced difficulty getting the claim paid, and then the insurance company paid only half of the cost.

Ms. Ann Doran, representing America's Health Insurance Plans, commented that advocates always have a good reason why a benefit should be mandated. However, she stated that state mandates can only influence commercially sold policies, which constitute only 29% of the insurance plans available. She added that the commercial sector of the market represents small businesses and individuals, the most price-sensitive portion of the health insurance market. The remaining plans are self-funded and governed by federal law.

Ms, Carol Cutter, representing the Department of Insurance, reported that the Department has no position on this issue.

Nurses in Schools

Phyllis Lewis, MSN, Department of Education, spoke on the implementation of HEA 1116-2007, which requires schools to report on the number of students who have a chronic disease and the number of school nurses. Ms. Lewis reported that the information will be collected with the ADM count performed on December 3, 2007.

Ms. Mary Conway, RN, Indiana Association of School Nurses, discussed the role of the school nurse and the changes in the practice over the years. She discussed the needs of school children with chronic conditions, such as diabetes and asthma. She also related that for a variety of reasons, a school nurse may be the only access to health care that many children have.

Ms. Jolene Bracale, RN, Indiana Association of School Nurses, discussed positive impacts on students' educational experiences that occur as a result of access to school nurses. She reported that the number of missed school days decline when there is a full-time nurse. She also reported that nationally there are 50% more 911 calls in schools that do not have school

nurses.

Hospital Construction Moratorium for New or Additional Facilities

Mr. Zach Cattell, Indiana State Medical Association (ISMA), commented on the ISMA's concerns regarding a moratorium on hospital construction. He stated that ISMA would not support a moratorium at this time.

Mr. Wes Cleveland of the American Medical Association (AMA) commented that academic medical centers bring resources into communities. He reported the outcomes of several federal studies with regard to the impacts of specialty hospitals on health care provision. Regarding the charge that specialty hospitals cherry-pick, or select patients with insurance or the ability to pay for services, the federal study suggested that a reduction in the Medicare reimbursement for procedures typically performed in specialty hospitals would help to level the playing field. The study suggested that specialty hospitals help to promote innovation, improve access to technology, and may increase quality of care and patient satisfaction. Other federal studies he cited found no statistically significant, conclusive evidence of patient access problems for the uninsured. Mr. Cleveland reported that Congress is currently considering a bill that would restrict hospital referrals by physicians to facilities in which they have ownership interests exceeding 2%.

In response to questions, Mr. Cleveland stated that the AMA position with regard to healthcare for the uninsured is to find a way to provide coverage for all uninsured individuals. With regard to a question regarding the value of a Certificate of Need (CON) process, he commented that CON is not a significant factor in keeping health care costs down, but may actually increase costs due to project delays and application requirements.

Mr. Tim Kennedy, representing the Indiana Hospital and Health Association (IHHA), reported that the IHHA does not have a position on this issue.

Hospital Designations and Definitions

Mr. Tim Kennedy, IHHA, reported that the Hospital Association is opposed to changing the names of entities due to definitions that are included in federal law. A different designation could impact specialty hospitals' eligibility for reimbursement from federal programs. The IHHA believes this would be counterproductive and not necessary.

Rep. C. Brown commented that he had raised this issue out of concern that people might look for services, especially emergency services, at specialty facilities that do not have them. He feels the designation of "hospital" for specialty facilities may be confusing to members of the general public.

Michael McGee, MD, an Emergency Department physician, commented that hospital designations on signs should be definitive with regard to the availability of emergency services.

Sen. Gary Dillon commented that all facilities should be capable of stabilizing emergency patients for transfer to a suitable facility.

Ways to Encourage MDs to Practice in Rural and County Hospitals

Mr. Zach Cattell, ISMA, stated that the ISMA is interested in addressing all the medically

underserved areas of the state - not just rural and county hospitals. He reported that two-thirds of the state qualifies as health profession shortage areas. He mentioned loan repayments, scholarship programs, and the expansion of the IU School of Medicine as actions that might encourage medical students to choose primary care practices and to locate in underserved areas. He added that the model program for this purpose was the National Health Service Corps, but that the federal money available for the loan repayment program was discontinued this year.

Gary Hospital Issues

Rep. Charlie Brown gave the Commission a brief overview of the background, the difficulties the Methodist Hospitals' Northlake Hospital located in Gary is experiencing, and some of the proposed solutions. Rep. Brown explained the background information regarding a consent decree that was the result of a lawsuit brought when the Southlake Hospital was built. The consent decree provided that Methodist could not do more for one facility than for the other. He reported that community meetings have been held with area leaders and Methodist Hospitals to make sure that quality services remain within the corporate limits of Gary. He added that there is interest from the IU School of Medicine in locating a medical campus in Gary in order to expand the medical education program located at IU Northwest. Rep. Brown said that building a new hospital affiliated with the IU School of Medicine could provide an economic engine for the Gary area. He stated that financing a new $220+ M facility is the problem; Methodist Hospitals does not have the financial ability to fund a new facility. Rep. Brown stated that Gary should have hospital care available within the corporate limits and that he supports a new 200-bed hospital facility for the city.

Sen. Edward Charbonneau reviewed background information on the Methodist Hospitals, and in response to a question responded that Methodist could not finance a new hospital at this time.

Mr. Claude Watts, CEO of Methodist Hospitals, commented that Methodist Hospitals is undergoing a revitalization. He added that Methodist Hospital wishes to be active in the discussions regarding the continuance of health care in Gary.

Dr. Jeff Wells, OMPP, reviewed healthcare problems in the Northwest Indiana region and suggested that the solution is to create an academic medical center partnered with the IU School of Medicine. The focus of such a center, in addition to offering all four years of medical school, would be on children's services and trauma care.

Pat Bankston, PhD, Assistant Dean and Director of the IU School of Medicine Northwest, testified that the School of Medicine is responding to the state's need for more physicians by increasing the medical school class size. The plan is to allow some students to take their third and fourth year of medical school training at regional campuses, such as IU Northwest. Currently, students may take the first and second years only at IU Northwest. The medical school supports the idea of a new hospital located close to the IU Northwest campus to serve as a site for the training of new physicians.

Lisa Harris, MD, CEO and Medical Director of Wishard Memorial Hospital in Indianapolis, discussed the integrated system of healthcare services that Wishard provides in Marion County. She commented that the hospital benefits enormously from the relationship with the IU School of Medicine. The research that takes place in the hospital also contributes to the ability to provide a high level of quality care. Dr. Harris reported that Wishard Hospital cares for the majority of the uninsured population in Marion County. Dr. Harris commented that four years

ago Wishard was experiencing serious financial difficulties, at which time the management reviewed the operation of the hospital for potential savings. Savings identified were reinvested in patient care improvements. Dr. Harris explained that Wishard Hospital has achieved financial stability and breaks even with the support of the Marion County Health and Hospital Corporation. She commented that potential federal Medicaid reimbursement cuts could upset that stability.

Michael McGee, MD, of the Northlake Hospital Emergency Department, gave a presentation on the need for a regional trauma center in Gary for Northwest Indiana. Dr. McGee pointed out that Methodist Northlake Emergency Department treats a very high percentage of penetrating injuries due to gunshot and stabbing as well as numerous blunt force trauma cases due to traffic accidents. He said that many people assume that Methodist Northlake is a trauma center. However, he noted that it is not designated as a trauma center nor is there a designated trauma center located anywhere in Northwest Indiana. Dr. McGee noted that in order to be classified as a level one trauma center, a hospital must have medical students and residents and house ongoing research programs. In order to create a regional trauma center, Methodist Northlake must have an affiliation with the IU School of Medicine. He further reported on efforts being made to obtain private and public funding to address this concern.

Richard Hug, Ph.D., Associate Professor, School of Public and Environmental Affairs at IU Northwest, reported on healthcare disparities and the opportunity to address them in Northwest Indiana. Dr. Hug presented statistics on the uninsured Hispanic and African American population and access to physicians and medications due to cost. He suggested that increasing health care manpower availability and affordable health insurance as well as a new facility could do much to address the problem of health care disparities. A new facility could also address increasing the supply of primary and specialty care physicians in the area as well as serving as a boost to the regional economy.

Sandra Gadson, MD, a nephrologist practicing at Methodist Hospital, commented that the information regarding health care disparities for African Americans and the poor has been known and discussed for 100 years; it is now time to do something about it. Dr. Gadson added that without a full-service hospital in Gary, the problem of access to care is exacerbated. Dr. Gadson commented that suggestions regarding the creation of a trauma center and increasing the nursing staff could be started programmatically now, but that eventually a new facility is needed. The funding of a new facility is the problem. She concluded by stating that a top quality health care facility is needed in Gary.

Ricardo Hood, MD, City Health Commissioner of Gary, said that he supports the IU School of Medicine expansion to a four-year program in Gary; he also supports the construction of a new facility. Dr. Hood emphasized that the needs for a trauma center and increased professional workforce were programmatic issues that could be addressed using the current facility. He stressed that the education programs could start now to begin addressing the access to care issues in Gary.

Ms. Karen Freeman-Wilson stated that generally there is agreement that a teaching hospital, trauma center, and full-service facility would be good for Gary. She added that the question is how to fund the project. She challenged the Commission to join in the effort to facilitate this mission since Gary cannot pass legislation by itself. She added that the Commission and the General Assembly can call the stakeholders to the table and help to facilitate the discussion necessary to get the project done. In response to a question about the local commitment towards the financial needs of the project, Ms. Freeman-Wilson responded by saying that people are skittish about property taxes and suggested that a local income tax may be a more

fair way to address the issue. When asked about the availability of money from the casino, Ms. Freeman-Wilson noted this was not an option for financing a hospital since a significant portion of the gambling dollars have been pledged for the previously approved baseball stadium.

Secretary Roob, FSSA, commented that the stumbling block to resolving the problem is finding a way to finance a facility estimated to cost $200 M or more. He estimated the debt service on a capital investment of this size would be about $20 M each year. Medicare and Medicaid reimbursements are not sufficient to allow for capital expenditures, and Gary Methodist has stated that they are not in a financial position to finance a new facility. The operating dollars are available to run a facility; financing the capital expenditure is the problem. Sec. Roob stated that the state is committed to helping Gary find the dollars to finance a new facility, but that the program needs to come out of Northwest Indiana.

Service Employees International Union (SEIU), Local 20, representative Ms. Anna Gibbons stated that due to the cost, the poor and uninsured are forced to forego preventative care and that the emergency department is the primary care giver to many Gary residents. She stated that she believed that with proper funding and support Methodist Hospital could provide sustained quality health care. She added that Gary needs a fully functional hospital but that legislation providing new funding streams is needed. She commented that the lack of a full-service hospital in Gary would affect the affluent as well as the poor and that the entire region lacks and needs access to a designated trauma center.

Mr. Lorenzo Crowell, SEIU Local 20, commented that the relationship of Methodist Hospital and the union was changing. The union has been attending monthly forums and is partnering with Methodist to make this project happen. He added that Gary is the third or fourth largest city in the state and it needs an optimum level of patient care to be available.

Stereotactic Radiosurgery/Cyberknife

Dr. Michael Hardacre defined stereotactic radiosurgery, also called cyberknife, and discussed its clinical applications. He explained the conditions that radiosurgery is currently used for and how eligible patients are selected for the procedure. He also presented potential new uses for this technology. He stated that candidates for the procedure may be referred because surgery is not an option and radiation therapy may be too debilitating. He gave examples of patients that have been treated with the technology. Dr. Hardacre discussed the question of whether radiosurgery is experimental, an extension of radiation therapy, or a niche market of cancer treatment. He explained the problems encountered by insured patients with denials for payment from their insurance carriers and to the widely varying coverage policies for the procedures.

Bernard Emkes, MD, described the clinical nature of radiosurgery as highly specialized treatment for specialized patients. He commented that the practice of medicine is being limited by insurance companies' claims payment decisions. Dr. Emkes stated that major insurance companies require studies and criteria which probably will never be available for radiosurgery procedures because the procedures work - it would not be ethical to deny the procedure to a patient in order to prove its efficacy in a double-blind study.

Mr. John Willey, representing Anthem Insurance Company, testified that two-thirds of individuals covered by health insurance have coverage that is regulated by the federal ERISA Act. Under these plans, the employer makes the policy decisions with regard to what is covered and what is not.

In response to a question regarding the state's coverage policy concerning radiosurgery for its employees, Ms. Linda Barrabee, Vice President of Provider Relations for Anthem, responded that the state uses the Anthem policy. Some of the radiotherapy procedures are covered; others are not. Ms. Barrabee stated that Anthem looks at the safety and efficacy of a procedure in determining coverage. She said that coverage decisions are not reviewed on the basis of cost but rather the efficacy of the treatment. In response to a question about how efficacy is determined for rare procedures, Ms. Barrabee stated that the efficacy review relies on peer review articles in various professional journals. When asked about insurance coverage determinations being equated to the practice of medicine, she stated that denial of coverage does not mean the patient cannot have the treatment - but they would have to pay for it.

Mr. Alfred Medjesky introduced himself as a cancer patient referred for radiosurgery. Anthem, his insurance carrier, denied payment for the procedure because the specific application he needs is still considered to be experimental. He explained that radiosurgery appeared to be his best treatment option since he had been told that he probably would not survive the necessary surgical procedure. Another treatment option, extensive radiation therapy, would leave him physically unable to return to work. He commented that the radiosurgery option that was denied for his condition would have been performed on an outpatient basis and would have allowed him to go back to work.

Methicillin-Resistant Staphylococcus Aureus (MRSA)

Dr. Judith Monroe, State Health Commissioner, reported that national statistics show there are 19,000 deaths annually attributable to MRSA, while there are 36,000 deaths due to influenza. She stated that the bacteria involved in the infections is common and generally not serious unless a patient is immunocompromised. She said that MRSA is attributable to the overuse of antibiotics and patients not taking the complete course of antibiotic therapy. Dr. Monroe added that community-acquired MRSA is not uncommon and has different risk factors than the more serious hospital-acquired infections. Persons at risk for community-acquired MRSA infections are generally young, involved in athletic programs, sharing towels or other personal items, or living in crowded conditions. Dr. Monroe stated that the best ways to avoid infections include hand washing, proper cleaning of surfaces and equipment, sanitizing linens, keeping personal items personal, and keeping wounds covered.

Dr. Monroe stated that outbreaks of MRSA are currently reportable to the Department of Health; there were a total of three outbreaks reported in 2003 and 2004. She also reported statistics on staph infections for 2006. Dr. Monroe told the Commission that ISDH is using the current media attention to create a teachable moment. An educational task force has been formed to let people know how to avoid infections by washing hands, cleaning athletic equipment, etc.

Ms. Laurie Fish, BSN, RN, reported that the CDC has released new recommendations to control multi-drug resistant organisms (MDRO). She reported that major local hospitals are participating in a collaborative effort to control MDROs. Meetings are held weekly under the auspices of a Regenstrief Institute Action Grant. The hospitals are screening patients for MDRO on admittance to intensive care units and again when they are discharged from the units. She reported that the Association for Professionals in Infection Control and the Indiana Patient Safety Center are launching a statewide collaborative effort to prevent and control the spread of MDROs in January 2008. This collaborative effort will include all hospitals and nursing facilities.

Dr. John Christenson reported that in his infectious disease practice at Riley Hospital he sees

many infected boils or bumps. He reported that recurrence is common and that often parents of affected children also are infected. Dr. Christenson reported that athletes acquiring MRSA is a problem, but that it is not a new problem.

Toy Recall and Update on Lead Poisoning Issues

Dr. Judith Monroe updated the Commission on the recall of toys containing lead. She reported that the last death attributed to lead poisoning occurred in Minnesota in 2005. She commented with regard to the toy recall that some companies were dealing proactively with the recall, increasing the level of testing on their products; other companies were not being so diligent. Dr. Monroe added that while at-risk children are required to be tested, the county health departments increased testing availability and tested many children for blood-lead levels after the toy recall. With regard to testing toys for the presence of lead, she recommended returning suspect toys rather than using tests that may be of questionable accuracy. She reported that there is already a statute in place prohibiting lead in products intended for children.

Dr. Monroe commented that while the toy recall had brought lead exposure to national attention, the presence of lead in older housing is the main source of children's exposure in Indiana. She reported that $8.2 million has been spent for housing control since 2005. Testing levels have increased by 20% since 2004, and Medicaid testing rates are at 37%. Dr. Monroe reported that elevated blood-lead levels are still being found and that the testing is particularly important since low levels of lead exposure may have no distinctive symptoms.

Childhood Obesity - Update on Childhood Growth Measurements

Dr. Monroe, State Health Commissioner, updated the Commission on the voluntary reporting of height and weight measurements of school children started in 2006. She reported that in 2005, 15% of school children self-reported that they were overweight. In 2006, the ISDH analyzed data that was voluntarily collected and reported by school corporations, demonstrating the incidence of overweight for the data collected was 7.6% higher than the self-reported data. Also of concern, the data showed that 2.3% of the K-12 students were underweight. Dr. Monroe stated that the voluntary reporting of student height and weight statistics is an ongoing activity.

V. COMMITTEE FINDINGS AND RECOMMENDATIONS

The Commission made the following recommendations.

PD 3297

PD 3297 requires a state employee health plan, a health insurance policy, or a health maintenance organization contract to provide coverage for radiosurgery to the same extent that the procedure is covered under the federal Medicare program.

After a motion was made and seconded, the Commission voted 17-0 in favor of recommending PD 3297 to the General Assembly.

PD 3336

PD 3336 requires hospitals and physicians to report each case of methicillin-resistant staphylococcus aureus infection to the State Department of Health. The PD also requires the State Department to report MRSA cases to the Governor and the Legislative Council.

A motion was made and seconded to amend PD 3336 by removing both reporting requirements and inserting language to provide the State Department Health emergency rule-making authority to require reporting of MRSA infections. The amendment was adopted by consent.

After a motion was made and seconded, the Commission voted 16-0 in favor of recommending PD 3336 as amended to the General Assembly.

PD 3384

PD 3384 establishes a Lead-Safe Housing Advisory Council to make recommendations related to lead poisoning prevention. It specifies certain requirements for laboratories, the State Department of Health, local health departments, residential rental property owners, child care providers, and retail establishments related to childhood lead-poisoning prevention. It also provides for a civil penalty to be assessed by the State Department for noncompliance with certain provisions. PD 3384 also establishes the Childhood Lead Poisoning Prevention Fund for outreach and prevention activities.

A motion was made and seconded to amend PD 3384 to include a home inspector as a member of the advisory committee. The motion was adopted by consent.

After a motion was made and seconded, the Commission voted 13-0 in favor of recommending PD 3384 as amended, to the General Assembly.

PD 3369

PD 3369 provides for the inclusion of cancer research as a charitable purpose to which an individual may choose to give all or part of the individual's income tax refund. PD 3369 also establishes the Cancer Research Trust Fund to be administered by the State Budget Agency.

After a motion was made and seconded, the Commission voted 14-0 in favor of recommending PD 3369 to the General Assembly.

PD 3388

PD 3388 specifies that the only occupation regulated by the State Department of Health subject to the Attorney General's investigative authority is the occupation of out-of-state mobile health care entities.

After a motion was made and seconded, the Commission voted 14-0 in favor of recommending PD 3388 to the General Assembly.

PD 3348

PD 3348 provides for a $25 penalty for a person who smokes in a passenger motor vehicle while a minor who is less than 13 years of age is in the vehicle. The penalty for a subsequent violation is $100. PD 3348 provides for the deposit of penalties into the Tobacco Use Prevention and Cessation Trust Fund.

A motion was made and seconded to amend the language to reflect that smoking in a passenger car while a minor less than 13 years of age is in the vehicle would be a secondary

violation. The amendment was adopted by consent.

After a motion was made and seconded, the Commission voted 10-4 in favor of recommending PD 3348 to the General Assembly. The motion failed, lacking a majority of the voting members of the Commission.

PD 3364

PD 3364 prohibits smoking in (1) public places; (2) enclosed areas of a place of employment; and (3) certain state vehicles. PD 3364 provides certain exemptions. It requires the Alcohol and Tobacco Commission to enforce the prohibition. The language makes it a Class B infraction to violate the smoking prohibition for the first offense and a Class A infraction if the person has three unrelated prior offenses. It also repeals the current clean indoor air law that prohibits smoking in public buildings.

A motion was made and seconded to amend PD 3364 to specify that local ordinances may be more restrictive than the statewide requirements. The motion to amend was adopted by consent.

Another motion was made and seconded to amend PD 3364 to add language that specifies that casinos and horse tracks are included in the applicable exemptions. The motion to amend PD 3364 was adopted by consent.

After a motion was made and seconded, the Commission voted 13-0 in favor of recommending PD 3364 as amended, to the General Assembly.

PDoc 1060

PDoc 1060 changes the term “methadone treatment” to “opioid treatment” for purposes of the law concerning certification of opiate addiction treatment programs. PDoc 1060 requires certification standards, certification, and licensure related to opioid treatment programs. It requires the establishment of certain fees and specifies violations and penalties. The PDoc also repeals the expiration of current law requiring a methadone diversion control and oversight program.

A motion was made and seconded to amend the PDoc to specify that the annual per-patient fees may not exceed $300 for each out-of-state resident and $20 for each Indiana resident. The motion to amend was adopted by consent.

After a motion was made and seconded, the Commission voted 13-0 in favor of recommending PDoc 1060 as amended, to the General Assembly.

PD 3387

PD 3387 requires the Office of the Secretary of Family and Social Services to enter into a memorandum of understanding with a nonprofit corporation to establish and operate an umbilical cord blood bank. PD 3387 requires physicians and participating hospitals to inform pregnant patients of the option to donate umbilical cord blood. It also requires the nonprofit corporation to establish an umbilical cord blood donation initiative to promote public awareness concerning the medical benefits of umbilical cord blood.

After a motion was made and seconded, the Commission voted 14-0 in favor of recommending PD 3387 to the General Assembly.

PD 3334

PD 3334 extends until June 30, 2013, the authority of the State Board of Dentistry to issue a dentist instructor's license for individuals not otherwise licensed to practice dentistry in Indiana. (Under current law, the authority expires June 30, 2008.)

After a motion was made and seconded, the Commission voted 14-0 in favor of recommending PD 3334 to the General Assembly.

PD 3368

PD 3368 requires the Health Finance Commission (1) to study during the 2008 interim domestic violence programs administered by the state and (2) determine the most appropriate state agency to administer these programs.

After a motion was made and seconded, the Commission voted 14-0 in favor of recommending PD 3368 to the General Assembly.

PD 3298

PD 3298 requires a state employee health benefit plan, a policy of accident and sickness insurance, and a health maintenance organization contract to provide certain prosthetic device coverage.

After a motion was made and seconded, the Commission voted 14-0 in favor of recommending PD 3298 to the General Assembly.

Concurrent Resolution

A concurrent resolution requesting Congress to enact legislation requiring employer group health benefit plans regulated under the federal Employee Retirement Income Security Act to provide certain coverage for prosthetic devices was considered.

After a motion was made and seconded, the Commission voted 14-0 in favor of recommending the proposed concurrent resolution to the General Assembly.

Concurrent Resolution

A concurrent resolution was considered supporting the location of a children’s hospital, a medical school teaching facility, and a trauma center in the city of Gary.

After a motion was made and seconded, the Commission voted 14-0 in favor of recommending the proposed concurrent resolution to the General Assembly.

PD 3230

PD 3230 provides that a defibrillator is not required to be located within the premises of certain health clubs. It removes a requirement for a specific cardiopulmonary resuscitation course

related to defibrillators in health clubs. It also specifies the fire department responsible for inspection of a health club for compliance with defibrillator requirements.

After a motion was made and seconded, the Commission voted 14-0 in favor of recommending PD 3230 to the General Assembly.

PD 3376

PD 3376 increases from a Class A misdemeanor to a Class D felony the penalty for (1) making a false or fraudulent statement when applying for a birth certificate or when applying for permission to inspect birth records; (2) altering, counterfeiting, or mutilating a certified copy of a birth certificate; or (3) using an altered, counterfeit, or mutilated copy of a birth certificate.

Upon final consideration, PD 3376 failed for lack of a motion.

Approval of Final Report

After a motion was made and seconded, the final report of the Commission with the inclusion of the testimony and the actions of the October 29 meeting was approved by a vote of 14-0.

W I T N E S S L I S T

July 30, 2007

Jessaca Turner-Stults, Legislative Director, Family and Social Services Administration
Jeff Wells, MD, Director, Office of Medicaid Policy and Planning
Lawren Mills, Policy Director, Governor's Office
John Viernes, Deputy Director, Division of Mental Health and Addiction
Karen Firestone, Audit Leader, Office of Fiscal and Management Analysis

August 15, 2007

Terry Whitson, Assistant Commissioner for Health Regulatory Services, Indiana State Department of Health
Arlene Franklin, State Long-Term Care Ombudsman
Faith Laird, Indiana Health Care Association
Jim Leich, Indiana Association for Homes and Services for the Aging
Robert Decker, Hoosier Owners and Providers for the Elderly
Robyn Grant, Long-Term Care Policy Director, United Senior Action
Karla Sneegas, Executive Director, Indiana Tobacco Use Prevention and Cessation Agency
Peggy Vols, Local Coordinator, Bartholomew County
Judith Monroe, MD, Commissioner, Indiana State Department of Health
Danielle Patterson, Senior Advocacy Director, American Heart Association
Enrico Garcia, MD, President, Indiana Association of Public Health Physicians and Local Health Departments
Cathy Calloway, National Government Relations Department, American Cancer Society
Debra Salefski, Radiation Therapist
Terrell Zollinger, MD, IU School of Medicine
Theresa Lubbins, MD
Pat McGuffy, Indiana State Chiropractic Association
Carol Cutter, Chief Deputy Commissioner of Health and Legislative Affairs, Indiana Department of Insurance
Mitch Roob, Secretary, Family and Social Services Administration
Andrew Satz, MD, Northside Anesthesia Services
Elizabeth Eichorn, Indiana State Medical Association
Greg Yust, President, Sagamore Health Network
Anne Houseworth, Department of Child Services

September 10, 2007

Joe Pritchard, Indiana Treatment of Opioid Dependency
Vidya Kora, MD, Indiana State Medical Association
Debbie Frazier
John Viernes, Deputy Director, Division of Mental Health and Addiction
Cathy Boggs, Director, Division of Mental Health and Addiction
Marifran Mattson, Indiana Amputee Insurance Protection Coalition
Kent Turnbow, Indiana Amputee Insurance Protection Coalition
Amy Mills
Ann Doran, representing America's Health Insurance Plans

Phyllis Lewis, MSN, Coordinator, Health Services, Indiana Department of Education
Mary Conway, RN, Indiana Association of School Nurses
Jolene Bracale, RN, Indiana Association of School Nurses

October 2, 2007

Dr. Bruce Bergland, Chancellor , IU Northwest
Zach Cattell, Indiana State Medical Association
Wes Cleveland, American Medical Association
Tim Kennedy, Indiana Hospital and Health Association
Michael McGee, MD, Emergency Department, Methodist Hospitals
Rudy Clay, Mayor of Gary
Sen. Edward Charbonneau
Jeff Wells, MD, Director, Office of Medicaid Policy and Planning
Mitch Roob, Secretary, Family and Social Services Administration
Pat Bankston, PhD, Ass't. Dean and Director, IU School of Medicine, IU Northwest
Claude Watts, CEO, Methodist Hospitals
Geraldine Darron-Simpson
Seferino Farias, MD, Chief of Surgery and Trauma, Methodist Hospitals
Richard Hug, PhD, Associate Professor, School of Public and Environmental Affairs, IU Northwest
Lisa Harris, MD, CEO and Medical Director, Wishard Memorial Hospital
Sandra Gadson, MD
Karen Freeman-Wilson
Anna Gibbons, Representative, Service Employees International Union, Local 20
Lorenzo Crowell, Service Employees International Union, Local 20
Lynn Olszewski, Director, Northwest Health Education Centers
Rep. Vernon Smith
Ricardo Hood, MD, City Health Commissioner, Gary
Eddie Tarver
Jeffrey Miller

October 29, 2007

Michael Hardacre, MD, Director of Radiosurgery, Cyberknife of Indianapolis
Bernard Emkes, MD
John Willey, Anthem Insurance
Linda Barrabee, Vice-President of Provider Relations, Anthem Insurance
Alfred Medjesky
Judith Monroe, MD, State Health Commissioner
Laurie Fish, BSN, RN, CIC, President, Indiana Chapter of the Association for Professionals in Infection Control
John Christenson, MD, Professor of Clinical Pediatrics, IU School of Medicine, Riley Hospital
Mary Studley, Indiana Cancer Research Advocacy Community
David Miller, representing the Attorney General's Office
Jessaca Turner-Stults, Legislative Director, FSSA
Bruce Hetrick
Cathy Boggs, Director, Division of Mental Health and Addiction